INITIAL REPORT OF AN ADVERSE EVENT

SECTION I: GENERAL INFORMATION

Hospital Name:_____

Person completing this report: _____

Title:_____Phone Number:_____Email:_____

Date of Report:_____ Date of Event:_____

Location of Event:_____

Area or Service (e.g. ED, OR, Med/Surg etc.):_____

Was TJC notified? YES NO

SECTION II: PATIENT INFORMATION

Patient #1 initials or patient number only: _____

Date of Admission: _____Age: _____

Admitting Diagnosis: _____

Current Status:_____

Prognosis:_____

Was the patient /family informed of the adverse event? YES NO

Patient #2 initials or patient number only: _____

Date of Admission: _____Age: _____

Admitting Diagnosis: _____

Current Status:_____

Prognosis:_____

Was the patient /family informed of the adverse event? YES NO

SECTION III: INTENTIONALLY UNSAFE ACTS

If the event was the result of an intentionally unsafe act such as abuse, please complete the following:

Position/Title: _____License #_____

If the staff person was licensed or certified, was the applicable professional board notified? YES NO

If the staff is employed through an agency or through a contract company and is not a hospital employee or member of the medical staff, please provide the employer's name.

_____

If the police were notified, please provide the jurisdiction and the report number if known:_____

SECTION IV: EQUIPMENT

If the event was the result of equipment or medical device malfunction or failure please provide the following information.

Equipment or Device: _____Model number:_____

Nature of Malfunction: _____

_____

Was FDA Notified? YES NO

SECTION V: DESCRIPTION OF THE EVENT: (Briefly describe the event and include the outcome to the patient, use additional pages if necessary)